Kansas Medical Assistance Programs

HEALTHCONNECT Kansas

From the office of the Fiscal Agent

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

Regranex Initial Request Form

Consumer Name: _____
Consumer Medicaid ID #: _____ **Date Of Birth:** ____/____/_____

Pharmacy Name: _____ **Provider Medicaid ID#:** _____
Phone Number: (_____)_____ **Fax Number:** (_____)_____

Ordering Physician Name (*please print*): _____
Ordering Physician Medicaid Provider ID#: _____
Phone Number: (_____)_____ **Fax Number:** (_____)_____
Wound must be evaluated at least weekly. Please indicate who will monitor wound status and complete daily dressing changes:_____
Wound Information: *(Please check appropriate type)*
(If more than one wound, this information must be provided for each wound.)
___Arterial ___Venous ___Pressure ___Diabetic ___Surgical ___Burn ___Other:_____
Wound Size: _____ Date: ____/____/_____ Location: _____
Stage: _____ Is there adequate blood flow to the area? _____
Is wound infected? ____ If yes, is infection under control with antibiotics? _____
Is the wound free of avascular and necrotic debris? _____
Has off-loading of pressure on the wound area been accomplished? _____
Are nutritional status and hydration adequate for healing? _____

Provide recent clear photo or diagram below; include measurements and date:

LAB: **DATE:**

Hgb: _____ / _____

Hct: _____/ _____

Alb: _____/ _____

Prot: _____/ _____

Other:

Treatment Plan:
_____
Other therapies/medications tried:
_____
By signing this form, the physician certifies that caregivers have been educated regarding the proper application, storage and cost of this medication, and that all responses provided are correct. A thin layer (1/16th") of Regranex should be applied **once daily** and the wound covered with a saline moist dressing, which should be changed again in 12 hours. Regranex must be refrigerated (do not freeze).
Concurrent use of other topical products is contraindicated.

Provider Signature: _____ Date: ____/____/_____

Completed form should be faxed to 1-800-913-2229.

Revised 3/2006

This form will be returned unprocessed if it is not completed in its entirety.